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PRESIDENTIAL ADDRESS

INDIAN PSYCHIATRY AT THE CROSSROADS - WHAT WE CAN DO WITH WHAT WE HAVE?[1]

S.M. CHANNABASAVANNA[2]

My dear colleagues, ladies and gentlemen: I have met you, and have spoken to you, on many different occasions and in many different capacities since 1968, when I joined the Indian Psychiatric Society; this, however, is my first opportunity to address you in the capacity of the President of this august body. My first words to you are an expression of thanks for having elected me to this revered position. I am honoured by your trust and deem it a privilege to serve the Society. I look forward with pleasure to the coming year and solicit your co-operation in the discharge of my responsibilities. Each of the honourable predecessors has delivered his inaugural address to the Society on a specific theme, and I will not break the tradition. My theme is, however, a theme with a difference. In the developed world, psychiatry, like other medical disciplines, includes in its investigational and therapeutic armamentarium a host of sophistications. These include facilities for routine (complete) metabolic and radiological worm-up, facilities for CT and MRI scans (if indicated), facilities for computerized EEG analysis, facilities for therapeutic drug level monitoring, choices of a wide variety of psychotropic drugs-I could go on! Here, in India, some of these facilities are available in most centres. Other, facilities are available in a few centres. Many facilities, however, are not available in most centres, while some facilities are not available at all. Furthermore, utilization of even those facilities as may be available are limited by economic constraints. With these few words, I arrive at the theme of my address. Indian Psychiatry is today at the crossroads, and I believe it will find its feet not in the ever elusive search for more and more esoteric facilities, but in the systematic application of available scientific knowhow. While I do not deny the vital need for more facilities, I believe that, in a nutshell, the issue at stake is: what (more) can we do with what we have? The answers are legion and range from biological psychiatric to psychosocial psychiatric domains; to establish my point, I will elaborate on one example from each extreme of the approach to the practice of psychiatry, and will conclude my address with brief reference to other areas worthy of mention. From the field of Biological psychiatry, I seek to focus on Electroconvulsive Therapy (ECT), a treatment method which has been the subject of extensive clinical and basic sciences research at NIMHANS for a decade. From the field of psychosocial psychiatry, I choose to focus on family therapy, a mode of therapy which NIMHANS has nurtured and developed using indigenous and eclectic models since the late 1960s, more so since 1976. As you would observe, both subjects-ECT and family therapy- are well within the purview of every psychiatrist in our country.

ECT IN INDIA: ISSUES FOR OPTIMIZATION OF PRACTICE

Convulsive thrapy was introduced by von Meduna, a Hungarian psychiatrist, in 1934. In 1938, Cerletti and Bini, neuropsychiatrists in Rome, replaced chemical convulsants with electrical seizure induction for more precise elicitation of the convulsion and with a greater margin of safety. Today, over half a century later, ECT remains the only somatic treatment to creditably survive the advent of psychotropic drugs. This half century has witnessed a number

1 At the 44th ANCIPS 92, on 23.1.92 at New Delhi. 2 Director, NIMHANS, Bangalore

of refinements in the practice of ECT. Although initially introduced for the management of schizophrenia, ECT was put to use for the management of a variety of other psychiatric states on an empirical basis. This was because psychopharmacology was not to make any meaningful contribution to therapeutics in psychiatry until the 1950s. However, rationalization of indications for ECT was soon established.

Other advances included modification of the seizure with muscle relaxants, introduction of brief-pulse currents and introduction of unilateral electrode placements - all of which occured in the 1940's. Subsequently, it was recognised that a certain minimum (central)seizure duration is necessary for the ECT seizure to have therapeutic effect. More recent advances are the introduction of constant current ECT devices and the recognition of the physiological importance of the ECT seizure threshold.

There have been many, other important advances in the field of ECT; I confine myself only to these few because these have had a major impact on the practice of ECT, and because these hold important lessons for us here in India.

Before I proceed, I must add that I have had the privilege of previewing the report of Agarwal, *et al.* (1992) on 'Practice of ECT in India. A Survey of the Indian Psychiatric Society'. Details in the report that caught my eye were that a large percentage of respondents used unmodified ECT, that virtually none used unilateral electrode placement or monitored seizure duration, and that the vast majority employed constant voltage, sinusoidal wave stimuli. These observations have occasioned me distress. I believe that a sea change is required in the way we practice ECT if the treatment is not to fall into discredit, or be stifled by legislation as in the USA.

Therefore, I wish to make four specific major recommendations to Indian psychiatrists for the practice of ECT, as well as a number of subsidiary recommendations. The major recommendations are that modified ECT be used unless contraindicated, the seizure duration be routinely monitored, that unilateral electrode placement be more frequently used, and that the constant voltage, sinusoidal wave stimulus be phased out. I shall consider each in turn.

1. MODIFIED ECT

Although systematic scientific documentation of the importance of the central (EEG) seizure with ECT was not to arrive until the work of Ottoson in 1960 (which documented reduced therapeutic efficacy of lidocaine-abbreviated seizures), by 1940 itself it was recognised that the peripheral convulsion, which produced somatic morbidity, could be dispensed with. Bennet, in 1940, introduced curare to contain the ictal muscle thrashing; by 1952, thanks to Holmberg and Thesleff, succinylcholine came into use as a muscle relaxant for ECT (Gangadhar *et al.*, 1992). Today, modified ECT is recommended for practice the world over unless specific contraindications exist to the use of anaesthesia or muscle relaxant (Royal College of Psychiatrists, 1989; American Psychiatric Association, 1990); dispensing with modification has in fact unequivocally been condemned as unethical (Andrade, 1990).

I foresee two practical difficulties in the recommendation that I am making favouring routine modified ECT. The first difficulty is that use of anaesthesia necessitates the presence of ancillary facilities ranging from a suction apparatus to an emergency resuscitation kit. This difficulty, however, should not be of great importance as the cost of such ancillary facilities is not very high. Incidentally, I firmly believe

that such facilities are essential even if unmodified ECT is given.

The second difficulty is that it is fast becoming conventional to requisition the services of an anaesthesiologist to supervise the premedication during ECT. While the presence of an anaesthesiologist is undoubtedly ideal, I argue that absence of availability of an anaesthesiologist cannot justify use of unmodified ECT. For such situations, hence, in which the services of an anaesthesiologist cannot be conveniently obtained, I belive that the treating psychiatrist can himself administer premedication provided that he has undergone a brief training period for the administration of anaesthesia, at some qualified centre. I make such a statement because the risk to the patient from unmodified ECT exceeds the risk from modified ECT administered by a psychiatrist with relevant anaesthesiological training.

In support of my contention is the study of Pearlman *et al.* (1990) which found that morbidity was no greater when psychiatrists handled the ECT premedication than when anaesthesiologists did so.

2. SEIZURE DURATION MONITOING

Although many controversies dog the mooted application of seizure duration during ECT, 2 points are clear: ECT seizure duration of less than 20-25 seconds is unlikely to purvey therapeutic benefit, and duration exceeding 120 seconds is likely to be associated with unacceptable risk for cognitive morbidity (Andrade, 1990). If such is the case, just as we would like to ensure that the patient is receiving a proper dose of antidepressant (e.g. nortriptyline), mood- stabilizing (e.g. lithium) or anticonvulsant (e.g. carbamazepine) drugs by therapeutic drug level monitoring, so too should we like to ensure that the 'dose' of ECT just administered was adequate, by sezizure duration monitoring.

While therapeutic drug level monitoring is at present beyond the reach of most psychiatrists for most drugs, monitoring the ECT seizure duration is not at all unattainable. Four methods have been described- the EEG method, the cuff method, the ECG method and the galvanic skin response method, of which the first two methods are important.

Although EEG monitoring during ECT has some limitations (e.g. concerning reliability estimation-see Guze *et al.*, 1989 etc.) it is preferrable because it can identify inordinate continuation of the central seizure despite absence of peripheral manifestations (Daniel, 1985). However, EEG monitoring is expensive and involves technology that is difficult to justify at grass roots levels of psychiatry as practised in India, especially as an inexpensive, convenient alternative exists.

The alternative to which I refer is the cuff method (Addersley and Hamilton, (1953). The cuff method is adequately reliable (Fink and Johnson, 1982) and requires apparatus that is no more sophisticated than the common sphygmomanometer. The procedure is as follows: to occlude the brachial artery, a BP cuff is inflated to about 200 mm Hg around the arm controlled by the dominant hemisphere (so that if unilateral, non-dominant ECT is administered, generalization of the seizure to both hemispheres can be confirmed). Next, the muscle relaxant is contralaterally injected. The relaxant, therefore, will not enter the occluded limb. After the inevitable fasciculations have died away, the ECT stimulus is administered. Simultaneously, the cuff is deflated (so that the limb that convulses does not become ischemic). As no relaxant has entered the occluded limb, it will convulse for the full duration of the seizure. This convulsion is timed. A 'motor' seizure duration is thus obtained.

As is apparent, application of this method of seizure duration monitoring is well within the scope of every ECT unit, and should become a routine in ECT practice and research in our country.

The practical handling of situations wherein observed seizure duration falls outside the window of 25-120 seconds lies out of the scope of my address to you but is, however, discussed elsewhere (e.g., Fink, 1987; Royal College of Psychiatrists, 1989; Andrade, 1990 and 1991a).

3. UNILATERAL ECT

Although unilateral electrode positioning was used as early as in 1942, it was not until 1949, when Goldman specified that the unilateral (UL) electrodes should overlie the right hemisphere to avoid the speech areas, that the UL ECT construct was clarified (Andrade, 1991b). Today, it is accepted that UL nondominant (ND) ECT is associated with less acute, subacute and longterm cognitive adverse effects than bilateral (BL) ECT. The only impediment to the replacement of BL with UL ECT is the question of the relative efficacy of UL electrode replacement.

By and large, with increasing methodological rigor, studies have demonstrated that UL and BL ECT are equivalent (Weiner, 1986). Weiner *et al.* (1986a & b) emphasized this finding in a well designed study. Equally compelling, however, is the work of the Sackeim group demonstrating that with threshold doses, ULND ECT is markedly inferior to BL ECT (Sackeim *et al.*, 1987). In their subsequent, recently conducted study, I learn that the suprathreshold doses ULND ECT remained inferior to BL ECT, although the difference this time was small.

I therefore conclude as follows: ULND ECT is considerably less morbid than BL ECT and, with optimization of technique (as demonstrated by Weiner *et al.*, 1986a&b), can be brought close to (if not at par with) BL ECT in term of efficacy.

These optimizations are: use of the d'-Elia electrode placement, use of moderately suprathreshold electricity doses, optimization of the electrode-skin interface to minimize electrical resistance, and monitoring of the seizure duration to ensure adequacy and generalization of the seizure. These recommendations were proposed by Weiner and Coffey (1986) and are discussed by Andrade (1991b).

I believe that UL ECT should, in our country, replace BL ECT except in situations in which need for maximization of efficacy and efficiency of the treatment is prominent - such as in drug resistant, suicidal, stuporous or psychotic patients, and in cases of psychotic (manic or otherwise) excitement. Use of ULND ECT is particularly important to India because of the frequent use, by Indian Psychiatrists, of ECT as the treatment method of first choice.

4. BRIEF-PULSE ECT

Conventional ECT devices, availabe and marketed in India, employ the sinusoidal stimulus waveform. With this waveform current is continuously flowing throughout the stimulus period - including for the period that the neurons are absolutely and relatively refractory as a result of having fired. Hence, a considerable part of the delivered stimulus is 'wasted'.

Linkage of the cognitive adverse effects of ECT to the electrical dose delivered led to the experimentation with ECT stimulus forms that reduced the stimulus dose, simultaneously reducing the above mentioned stimulus wast-

age. By 1942, Friedman and Wilcox, and Delmas-Marsalet, have developed modifications of the parent sinusoidal waveform (SW). Liberson and Wilcox reported the first clinical use of brief pulse (BP) stimuli. As the name indicates, the stimulus comprises brief pulses of current delivered at periodic intervals (Gangadhar and Andrade, 1989a & b).

Literature suggests that BP ECT is less cognitively toxic than SW ECT, particularly acutely after ECT; BP ECT is also close to, if not on par with, SW ECT in term of efficacy and efficiency (Andrade, 1990). Accordingly, there seems to be a good case for the replacement of SW ECT with BP ECT. One study worth noting in this context is that of Weiner *et al.* (1986a & b) wherein ULBP ECT was found to be therapeutically equivalent to BLSW ECT while being associated with considerably less cognitive adverse effects in both short and long terms.

A problem in India is that BP ECT devices, which are in the process of being introduced in the Indian market, cost 5-6 times as much as the average SW ECT devices. A further problem is that the Indian BP ECT devices deliver constant voltage - not constant current - stimuli. In patients with high seizure thresholds, constant voltage BP stimuli may have compromised therapeutic effect.

While the expense of a BP device can in time be recovered, study is warranted to the efficacy and efficiency of constant voltage BP ECT as compared with conventional (constant voltage) SW ECT. If the merits of constant voltage BP ECT can be demonstrated, in course of time SW ECT can be phased out and replaced with BP ECT.

In time, too, development of indigenous constant current BP devices is necessary. The device marketed abroad, at current foreign exchange conversion rates, are astronomically priced (e.g., at Rs. 2 lakhs.)

A final note is that on some patients, ULBP ECT may be sub-optimal and the physician must be prepared to change over to BLBP or BLSW ECT if initial response is poor (Andrade, 1990).

5. OTHER ISSUE

Although I have spoken of 4 specific areas in which I hope to see an improvement in the practice of ECT in India over the coming years, I add that there are many other areas in which improvement is warranted. Thus, for example, antidepressant drugs should best be avoided during ECT as these may lower the seizure threshold as well as predispose to increased cognitive morbidity. Benzodiazepines must similarly be avoided as these raise the seizure threshold, or shorten seizure duration, thus compromising the benefit afforded by the treatment. ECT should be continued until optimum benefit, suitably defined and operationalized, is obtained; there is no rationale for giving 'extra' ECT to ensure stability of recovery, for continuation medication can achieve this goal. ISI specifications are necessary to cover ECT devices; these instruments require to be periodically tested for fidelity.

I have taken ECT as an example from the biological spectrum of the psychiatry, and have laid so much of stress on optimization of its use, for two reasons. Firstly, ECT is widely used in India, even as a primary indication (instead of as a last resort). Secondly, the treatment is much misunderstood, and carries a bad press, because of the use of electricity and because of the production of a convulsion. Therefore, it behoves the clinician to do all that lies within his power to ensure that the treatment is not misused, that it is used to the best possible advantage to the patient, and that it does not arouse adverse publicity. I may add that the consumer movement in the country is gaining

ground, and it would be tragic if an important therapeutic tool were to be legally or otherwise shackled because of injudicious clinical application.

FAMILY PSYCHIATRY: LESSONS FOR INDIA

Coming now to Social Psychiatry and the role of the family in the mental health:

Psychotherapy is an interpersonal process involving the analysis and correction of maladjustment by psychological means, within the framework of an existent psychological theory. Family therapy is a specialized form of psychotherapy wherein the family - and not the individual - is the client, and wherein intrapersonal processes - and not interpsychic processes alone - are the focus of therapy. Barker (1981) compares individual psychotherapy with the maintenance of integrity of the mechanical functioning of a car and family therapy with the maintenance of smooth flow of traffic on a highway; the former addresses itself to a single unit while the latter is concerned with interactions between units as well.

By and large, treatment of psychological dysfunction had centered around the individual until the turn of the century, when families were involved in the therapy of dysfunctional children. Subsequently, psychoanalytic thought highlighted the importance of the family in the genesis of symptoms or deviance.

Drawing from his experience in psychoanalysis, and from the understanding of how interpersonal processes may influence intrapsychic processes, Nathan Ackerman in 1958 published the first formal text on family therapy, titled 'The Psychodynamics of Family Life'. Today, just as there are many schools of individual psychotherapy, so too are there many schools of family therapy - each with its own basis, philosophy and modus operandi.

Family therapy in India evolved from the work of Dr. Vidyasagar, Superintendent at the Amritser Mental Hospital, who, faced with a shortage of accomodation for patients awaiting admission, housed them under a single canvas canopy. In a month's time he replaced the canvas canopy with individual tents, one family to a tent, and began therapy of the index case in this situation. Thus, the family was the environment for the treatment of the patient, and not other patients in a hospital ward (Vidyasagar, 1971; Bell, 1971).

Today, several centers in India offer facilities for family therapy. Regrettably, though, the vast majority of Indian psychiatrists continue to focus primarily and almost exclusively on the index case. It is hope that Indian psychiatry grows to the greater involvement of the family in therapy, and I present my case towards the achievement of such a goal.

CIRCULARITY

The argument in favour of focussing on the family in therapy, instead of on the individual alone, is presented in two steps.

First, there is no denying that the family is the structural and the functional unit of society, and not the individual alone. Hence, just as one treats the individual as a whole when an organ is diseased, so too is it necessary to enter the family as a whole into therapy when a component member becomes psychologically dysfunctional.

Second, in clarification of the above, arises the Principle of Circularity: Psychopathology in one family member can generate and maintain psychopathology in the

family and vice-versa (Channabasavanna and Andrade, 1987). This tenet comprises the foundation of the family approach to psychiatry, and seeks to change the living structure of the person rather than to pluck him out of a situation and change him.

I cite three examples to drive home my point about circularity and the importance of the family approach in routine psychiatric care. Alcoholism, depression, conduct or emotional disorders of childhood and adolescence, sexual dysfunction and schizophrenia are common problem in psychiatry. In each of these, the conventional approach is to do therapy with the individual as the primary if not the sole focus. However, such an approach is suboptimal; consider:

Alcoholism in a husband tends to create emotional, social, financial and other stresses for cohabiters in the household. In consequence, the wife may become depressed, or a child conduct or emotion-disordered. The depression in the wife compromises her adaptive competence and predisposes to or provokes negative interactional patterns; similarly, emotional or behavioural problems in the child can pressurize or frustrste the father. As an unconscious measure of retaliation, and perhaps to 'escape', the husband continues or increases his drinking. Thus, alcoholism compromises the psychological functioning of the family members and this compromised psychological functioning stimulates further drinking. A vicious circle develops.

Schizophrenic symptomatology is also stressful for cohabiters in the household and leads to criticality, hostility and/or over-involvement as retaliatory or compensatory reactions; as recent research has shown (Leff, 1985), these reactions tend to maintain illnesss behaviour or precipitate a relapse from a state of remission. Once again, a vicious circle arises.

Marital discord arising out of any cause - major or minor - can precipitate sexual dysfunction such as erectile impotence, vaginissmus, anorgasmia, etc. One or both spouses may be affected. The resultant sexual dissatiafaction aggravates the marital discords, which in turn further disturbs sexual functioning etc., - the vicious circle yet again!

In the three examples that I have cited, three different patterns of origin of circularity are demonstrated: individual psychopathology generating individual psychopathology; individual psychopathology generating family psychopathology, and family psychopathology generating family psychopathology. Such origins notwithstanding, I stress that:

- It is very often difficult (and sometimes meaningless) to search for where and how the psychopathology originated - in the individual or in the family. This is especially true with longstanding problems, for circularity tends to develop a measure of autonomy over time, irrespective of the manner in which it had been kindled.

- It is often difficult (and again, often meaningless) to search for the member who is playing the greater role in circularity. This is because family interactions are complex, and subtle factors (which emerge as therapy progress) may contribute as much to circularity as overt factors.

- Consequent upon the above, the golden rule is that wherever circularity of psychopathology originated or seems to be maintained, therapy is unlikely to be successful unless both individual and family processes are subjected to correction (Channabasavanna and Andrade, 1987; Channabasavanna *et al.*, 1987).

I add that 'circularity' is a term that suggests that the dysfunctions remains in a single

plane of severity. This is, however, seldom the case for circularity of psychopathology tends to produce an upward spiral of psychological dysfunction in the individual and/or the family and leads to an adaptative breakdown in an individual, or to a family crisis.

From my arguments, it should be apparent that whatever the psychopathology and however innocuous it may seem, family repurcussions are inevitable. This exemplifies the 'systems' perspectives- change in one unit of a system inevitably occasions change in the entire system, and vice versa; once a dysfunctional equilibrium has been established, the system tends to resist spontaneous corrective change. Thus, whenever maladaptive change occurs, even if primarily in an individual, family intervention is indicated.

DEPTH OF INTERVENTION

My discussion leads to the conclusion that the family must be addressed in every case that present itself to the psychiatrist. Although such a recommendation may seem radical, I affirm that it is sound in principle. However, three factors need to be considered.

1. Psychopathology: The nature and depth of circularity and psychopathology would define the nature and degree of family intervention, as well as define the number of family member who need to be involved in the therapy.

2. Practical issues: Practical details such as availability of key family members, and their motivation to participate in therapy, also define the depth of family intervention undertaken.

3. Therapist characteristics: Many therapist characteristics define the depth of family intervention. These include availability of time, degree of psychological-mindedness, comfort with dealing with interpersonal or psychological as opposed to biological issues, theoretical orientation and background, and training in family approaches, amongst other matters.

THERAPIST STANCES

Depending on the approach, the Group for Advancement of Psychiatry (GAP) report on family therapy has identified three therapist stances. The position 'A' therapist views the individual as a container of psychopathology; family therapy is thereby handled with a predominantly individual slant.

The position 'Z' therapist views the family as an integral unit which expresses its psychopathology in an individual; family therapy is thereby handled with a predominantly family slant.

Midway between 'A' and 'Z' is the position 'M' therapist who more or less divides attention equally between individual and family. Thus the position 'A' therapist adopts a 'family approach to psychiatry' stance, and the position 'Z' therapist a classical 'family therapy' stance.

I make the specific recommendation that the position 'A' stance is desirable as a routine clinical practice in mental health; the use of position M & Z would depend on clinical need as well as on the therapists' training. I consider that in the Indian setting, given the Indian cultural background and the overall lack of training that most psychiatrists have in family approaches, the position A or M stances are largely practicable; the position Z stance may fruitfully be employed at specialized centers where facilities for intensive training and extensive experience exist, or following such training.

I wish to stress that there is a great need to improve training of Indian psychiatrists in family approaches, as well as to develop an Indian idiom of family therapy. As you all know,

the family is traditionally a strong unit in Indian cultural context, and is a resource or form of primary social support system that should be maximally utilized in the care of the psychologically dysfunctional individual.

WHAT ELSE WE CAN DO WITH WHAT WE HAVE

Although my discourse has so far confined itself to ECT and to family therapy, there is a very great deal more in both biological and psychosocial realms of psychiatry that can be meaningfully tackled to the advantage of Indian psychiatry.

We don't need more and more 'newer neuroleptics' and 'newer antidepressants' - just a few affordable ones that have an acceptable spectrum of adverse effects. Fixed dose drugs combinations should be stoped. Polypharmacy, unless essential, is an unacceptable practice. Use of drug schedules should be rationalised - such as preferring once daily to thrice daily regimes. Unnecessary drug therapy should be avoided - such as confining use of anticolinergic drugs to the first two weeks of institution of neuroleptic therapy (to guard against dystonia), and using it subsequently only if extrapyramidal syndromes are unequivocally present.

There is also need to research traditional systems of medical care (ayurveda, homeopathy, etc.) while other traditional systems such as yoga and transcendental meditation can be fruitfully integrated into a treatment plan for neuroses, psychosomatic disorders and so on (Nagarathna and Nagendra, 1985; Andrade and Andrade, 1991; Bhaskaran, 1991).

There are many important thrust areas on the psychosocial front of psychiatry, all of which need to be tackled in our country as a priority and none of which need inputs beyond that which can be mobilized utilizing available resources. I refer to my community-based approach in particular.

There are just 2000-2500 psychiatrists in India, catering to a population in excess of 800 million. The majority of these psychiatrists reside in urban conglomerations, while the bulk of our country's population resides in rural areas. Therefore, there is a pressing need to provide basic mental health care to an enormous segment of the population. Besides implimentation of the National Mental Health Programme, this can be done in many ways. Established psychiatric institutions can run satellite clinics in identified rural centers, conduct community based camps in 'adopted' districts and organise relevant mental health programmes.

In both rural and urban areas, special programme can be conducted, and available resources tapped. Programmes need to be developed for vulunrable populations. These include the youth (for matters such as substance abuse, social morality, sex and family life), women, the elderly, the terminally ill, the chronically (Medically) ill as well as the unfortunates who are in need of rehabilitation - a much neglected area.

A fundamental strategy to be adopted in the implimentation of such programmes is the utilzation of available community resources. General practitioners, a first line of defence for most illnesses, require orientation to the identification and management (at least for basic care) of psychiatric disorders. Traditional faith healers are often another first line of defence especially in rural India. While reassuring these healers that the intention is not to usurp their positions, an attempt can be made to enable them to differentiate organic and psychotic from functional disorders; the former need to be refered to specialized psychiatric caregivers. Teachers can be taught how to identify indices of distress in their students; children are a vulnerable population, and teachers may at

times be in a better position (than parents) to identify deviance and distress. Religious leaders can be similarly educated, for it is to their counsel that many people turn when disturbed. Existing community set-ups whether religious, charitable, social or otherwise, can also be utilized.

The goal should be prevention of psychological disturbance at all levels - primary, secondry and tertiary preventation - as well as the promotion of well-being (Diener, 1984) in individual, family and social life, and not merely the prevention of disease (WHO). Practice of psychiatry should become holistically biopsychosocial (Kuruvilla, 1991).

Channels for information dissemination to Indian psychiatrists should improve and should not depend on communication from the pharmaceutical industry. In this connection, our official organ, the Indian Journal of Psychiatry, would do well to present in each issue, instead of original research only, an educative column such as on psychopharmacology, or on practical management issues, or on advances in the field. Such is already being practised in some journals such as Hospital and Community Psychiatry. While the CME programme organised by our society is also valuable, it comes just once in a year and is attended by a small group of psychiatrists only.

I may add that information dissemination should extend to the lay public too, in the form of educative articles and programmes in the mass media, to promote public participation in mental health, improve utilization of available services, and foster rational attitudes towards mental illness.

Psychiatric services should become available, affordable, accessable and acceptable to Indian public. As I have attempted to show, being a comparatively fledging medical science we have a long way to go, and there is a great deal that we can do with the resources that we have before we hanker for more.

With these few words, I thank you for your attention, and hope that the coming years usher in a new era - a golden era - for Indian Psychiatry.

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